MoHealthNet
PROVIDER BULLETIN

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FEDERAL DEFICIT REDUCTION ACT SECTION 6032

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Federal Deficit Reduction Act Section 6032

This provider bulletin is to remind participating MO HealthNet Division (MHD) providers and MHD Managed Care Organizations of the requirements of Section 6032 of the Federal Deficit Reduction Act (DRA) of 2005 and in Missouri State Regulation found at 13 CSR 70-3.020(12) and 13 CSR 70-3.030(3)(A)43.

On February 8, 2006 the DRA of 2005 was signed into law. Among the several sections that impact MHD providers is Section 6032 which imposes new requirements on any entity that receives or makes at least $5 million in annual MO HealthNet payments.

Specifically, Section 6032 requires that, as a condition of payment, each entity shall:

> "(A) establish written policies for all employees of the entity (including management), and of any contractor or agent of the entity, that provide detailed information about the False Claims Act established under sections 3729 through 3733 of Title 31, United States Code, administrative remedies for false claims and statements established under Chapter 38 of Title 31, for false claims and statements established under Chapter 38 of Title 31, United States Code, any State laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in Federal health care programs (as defined in section 1128B(f));
>
> (B) include as part of such written policies, detailed provisions regarding the entity's policies and procedures for detecting and preventing fraud, waste and abuse, and
>
> (C) include in any employee handbook for the entity, a specific discussion of the laws described in subparagraph (A), the rights of employees to be protected as

> whistleblowers, and the entity's policies and procedures for detecting and preventing fraud, waste and abuse."

The Centers for Medicare and Medicaid Services (CMS) has interpreted the word "entity" to include:

> "A governmental agency, organization, unit, corporation, partnership, or other business arrangement (including any Medicaid managed care organization, irrespective of the form of business structure or arrangement by which it exists), whether for-profit or not-for profit, which receives or makes payments, under a State plan approved under title XIX or under any waiver of such plan, totaling at least $5,000,000 annually." CMS SMDL #06-024, (Dec. 13, 2006).

CMS has clarified that payments to the entity are to be aggregated for purposes of the annual threshold:

> "If an entity furnishes items or services at more than a single location or under more than one contractual or other payment arrangement, the provisions of [Section 6032] apply if the aggregate payments to that entity meet the $5,000,000 annual threshold. This applies whether the entity submits claims for payments using one or more provider identification or tax identification numbers." CMS SMDL #06-024, (Dec. 13, 2006).

CMS has clarified that the annual threshold is based on the federal fiscal year:

> "An entity will have met the $5,000,000 annual threshold as of January 1, 2007, if it received or made payments in that amount in Federal fiscal year 2006. Future determinations regarding an entity's responsibility stemming from the requirements of [Section 6032] will be made by January 1 of each subsequent year, based upon the amount of payments an entity either received or made under the State Plan during the preceding Federal fiscal year." CMS SMDL #06-024, (Dec. 13, 2006).

State regulations filed March 30, 2007 and effective October 30, 2007 and September 30, 2007 at 13 CSR 70-3.020(12) and 13 CSR 70-3.030(3)(A)43 address the requirements set forth in Section 6032 of the DRA of 2005.

Section 6032 Compliance

Any MHD provider, including any MHD managed care organization, which receives or makes $5 million in annual MHD payments, must comply with Section 6032 as a condition of receiving MHD payment. The $5 million amount, for MHD purposes is based on paid claims, net of any adjustments to those claims.

If a provider furnishes items or services at more than a single location or under more than one (1) contractual or other payment arrangement, the provisions apply to that provider if the aggregate payments total five (5) million dollars or more. A provider meeting this dollar threshold and having more than one (1) federal tax identification number shall provide MHD written notification of each associated federal tax identification number, each associated provider name and each associated Medicaid provider number by September 30 of each year.

The MHD Program Integrity Unit (PIU) will identify those entities that meet the $5 million annual threshold from the preceding Federal Fiscal Year. This identification will take place in the quarter ending December 31 of each year. Each identified entity will be directed to be in compliance by January 1 and maintain proof of compliance with provisions by March 31 of the following year.

Any provider that claims an exemption from the provisions of Section 6032 must provide proof by writing to the MO HealthNet Division of such exemption within thirty (30) days of the notification by MHD that the provider met the five (5) million dollar threshold for the proceeding federal fiscal year.

To comply with Section 6032, the provider must ensure that no later than January 1, it has implemented all of the following requirements:

1. The provider must establish and disseminate written policies for all employees (including management) that provide detailed information about the federal laws identified in Section 6032(A) and any Missouri laws imposing civil or criminal penalties for false claims and statements, or providing whistleblower protections under such laws. These policies must be adopted by its contractors or agents.

2. In addition to the detailed information regarding the federal and state laws, the provider's written policies must contain detailed information regarding the provider's own policies and procedures to detect and prevent fraud, waste, and abuse in federal healthcare programs, including Medicare and Medicaid.

3. The provider must provide a copy of its written policies to all of its employees, contractors, and agents of the vendor. Written policies may be on paper or in electronic form, but must be readily available to all employees, contractors, or agents.

4. If the provider maintains an employee handbook, the provider must include in its employee handbook a specific discussion of the federal and state laws described in its written policies; the provider's policies and procedures for detecting and preventing fraud, waste, and abuse; and the right of its employees to be protected from discharge, demotion, suspension, threat, harassment, discrimination, or retaliation in the event the employee files a claim pursuant to the Federal False Claims Act or otherwise makes a good faith report alleging fraud, waste, or abuse in a federal healthcare program, including Medicare and Medicaid, to the provider or to the appropriate authorities.

5. Any MHD provider that receives or makes $5 million or more in annual MO HealthNet payments must certify annually that it complies with Section 6032 of the DRA. Specifically, each year, providers must complete and retain a signed letter attesting that they have read and understood Section 6032 of the DRA. The letter must also state that the entity has written policies and procedures that provide detailed information concerning preventing and detecting fraud, waste and abuse in Federal health care programs, civil or criminal penalties for false claims and statements, and whistleblower protections under federal and state law.

ANNUAL OVERSIGHT

MO HealthNet Division will have the responsibility to ensure compliance with the requirements of Section 6032 of the DRA. Compliance will be determined through retrospective reviews. Annually, MHD will randomly sample providers to verify compliance. Providers must be prepared to submit the following items within 10 days of the request of the state agency:

- Copy of the signed and dated attestation letter.
- Copies of written or electronic policies that meet the federal requirements and the date that these policies and procedures were implemented and/or revised.
- Written description of how the policies are made available and disseminated to all employees and to all employees of any contractor agent for each provider or provider entity.
- Copies of any employee handbook, if the provider maintains a handbook and the date that the handbook was updated to include DRA related information.

Compliance with these requirements is mandatory. Any provider or provider entity that fails to comply with the annual attestation letter or the submission of information is subject to sanction, including suspension of MO HealthNet payments or termination from participation in the MO HealthNet Program.

Provider Bulletins are available on the MO HealthNet Division (MHD) (Formerly the Division of Medical Services) Web site at http://dss.mo.gov/mhd/providers/pages/bulletins.htm. Bulletins will remain on the Provider Bulletins page only until incorporated into the provider manuals as appropriate, then moved to the Archived Bulletin page.

MO HealthNet News: Providers and other interested parties are urged to go to the MHD Web site at http://dss.missouri.gov/mhd/global/pages/mednewssubscribe.htm to subscribe to the electronic mailing list to receive automatic notifications of provider bulletins, provider manual updates, and other official MO HealthNet communications via E-mail.

MO HealthNet Managed Care: The information contained in this bulletin applies to coverage for:

- MO HealthNet Fee-for-Service
- Services not included in MO HealthNet Managed Care

Questions regarding MO HealthNet Managed Care benefits should be directed to the patient's MO HealthNet Managed Care health plan. Before delivering a service, please check the patient's eligibility status by swiping the MO HealthNet card or by calling the Interactive Voice Response (IVR) System at 573-635-8908 and using Option One.

Provider Communications Hotline
573-751-2896